AMENDED: Managed Long Term Services and Supports (MLTSS)
Opportunity for Public Comment

NOTE: After publishing the initial public comment notice, DMAS has given additional consideration to the importance and need of complete and thoughtful comment solicitation by interested stakeholders. While this is not a process that requires formal public comment solicitation by the department, the expertise and perspective of DMAS' stakeholders is appreciated and respected and therefore the public comment period has been extended from June 1, 2015 to June 16, 2015 (30 days).

Purpose of Request: This is an opportunity to provide public comment on the proposed design and implementation of DMAS' program initiative to transition remaining fee-for-service populations into a mandatory managed care program. This is not a formal solicitation and the Department of Medical Assistance Services (DMAS) will not award a contract based on submitted responses. This is strictly a means for DMAS to obtain initial stakeholder input in the design of a Managed Long Term Services and Supports (MLTSS) program.

Important Date: If you or your organization plans to submit public comments, **please send your comments to VAMLTSS@dmas.virginia.gov by 5:00 p.m. on June 16, 2015.** There will be additional opportunities for public comment. The Department will also continue its longstanding practice of meeting regularly with stakeholder groups, providing information and gathering additional input on the important features of an MLTSS program.

Length of Responses: Responses should be typed, page-numbered, and should be no more than a total of 5 single-spaced pages in length using 12-point Arial font.

Legislative Directive: The 2013 *Virginia Acts of Assembly* directed DMAS to implement three phases of Medicaid reform. The third phase is "to include all remaining Medicaid populations and services, including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems." (Item 307.RRRR.4. - http://lis.virginia.gov/131/bud/hb1500chap.pdf). The 2015 *Virginia Acts of Assembly*, (Item 301.TTT) again directed DMAS to expand principles of care management to all geographic areas, populations, and services under programs administered by the Department.

This Opportunity for Public Comment will help DMAS meet both of these directives.

Virginia's Experience with Coordinated Care: Virginia has extensive experience with implementing managed and coordinated care programs. To date, approximately 74 percent of all Virginia Medicaid beneficiaries are enrolled in some form of managed or coordinated care. Specifically,

- Virginia began operating managed care in 1996 in the Tidewater region. Now named Medallion 3.0, the program serves over 700,000 individuals statewide, including low-income children and families and non-dual eligible individuals who are seniors or who have disabilities.

- DMAS operates a full-risk managed care program for individuals over the age of 55 who receive Medicare and Medicaid benefits–the Program for All Inclusive Care for the Elderly (PACE). The PACE program provides all Medicare and Medicaid benefits under one entity anchored by an adult day health center. There are thirteen (13) PACE sites located throughout the Commonwealth, serving just over 1,300 individuals.

- In April 2014, DMAS implemented the Commonwealth Coordinated Care (CCC) Program- a demonstration in partnership with the Centers for Medicare & Medicaid Services (CMS) that serves individuals receiving Medicare and Medicaid (dual eligibles) under a capitated full-risk managed care model. Approximately 27,000 individuals are served in this program in select regions in Virginia.

- Most recently, in December 2014, DMAS transitioned non-dual eligible Elderly or Disabled with Consumer Direction (EDCD) Waiver individuals into Medallion 3.0 for their acute and primary care services. Referred to as the Health and Acute Care Program (HAP), these individuals receive their waiver services through Medicaid fee-for-service (FFS) as "carved out" services. Almost 8,000 individuals participate in this program.

Virginia's Current HCBS Program: Most of the individuals who continue to receive services through the Medicaid FFS system are dual eligibles (except for those participating in PACE or CCC) and individuals receiving long-term services and supports (LTSS), either through an institution or through one of DMAS' six (6) home and community-based services (HCBS) waivers: (i) Alzheimer's Assisted Living; (ii) Technology Assisted; (iii) Elderly or Disabled with Consumer Direction; (iv) Day Support for Persons with Intellectual Disabilities (DS); (v) Intellectual Disabilities (ID); and, (vi) Individual and Family Developmental Disabilities Support (DD).

Virginia's Upcoming Proposed Plans for MLTSS: Building on DMAS' managed and coordinated care experiences, DMAS plans to implement an MLTSS program to provide individuals with a more integrated and seamless delivery system starting in 2016.

Please note, at this time MLTSS for individuals enrolled in the DS, ID, and, DD Waivers is being considered for their acute and primary care services, **only**. While DMAS is exploring the feasibility of managed/coordinated care models for the ID, DD, and DS Waivers, these individuals will continue to receive their home and community-based LTSS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services completes the redesign of these Waivers.

Nationally, the number of MLTSS programs has increased significantly over the past decade and is expected to increase even more as the number of seniors expands. MLTSS programs represent arrangements between state Medicaid programs and managed care plans or other contracted entities. These entities receive combined payments to fully integrate an individual's primary, acute, behavioral health and HCBS and/or institutional services.

MLTSS programs provide an opportunity to create a seamless, integrated health services delivery program. Some of the goals of MLTSS include:

- Improved quality of life, satisfaction, and health outcomes for individuals who are enrolled;
- A seamless, one-stop system of services and supports;
- Service coordination that provides assistance in navigating the service environment, assuring timely and effective transfer of information, and tracking referrals and transitions to identify and overcome barriers;
- Care coordination for individuals with complex needs that integrates the medical and social models of care, ensures individual choice and rights, and includes individuals and family members in decision making using a person-centered model;
- Support for seamless transitions between service/treatment settings;
- Facilitation of communication between providers to improve the quality and cost effectiveness of care;
- Arranging services and supports to maximize opportunities for community living; and,

- System-wide quality improvement and monitoring.

Opportunity for Public Comment: As DMAS moves forward with developing an MLTSS program, significant and ongoing stakeholder input will be necessary to ensure that this initiative effectively meets the needs of individuals and providers.

Questions for Public Comment

(As a valued stakeholder you are invited to respond to any or all of the questions below.)

General:

1. What would you like to see as the top three significant features of an MLTSS program?
2. What suggestions do you have as DMAS continues to explore the feasibility of including acute and primary care in the MLTSS program for individuals enrolled in the ID, DD, and DS Waivers?

Beneficiary Experience:

3. What protections do you consider to be essential for individuals in an MLTSS program (e.g., enrollment/disenrollment services, including choice counseling; offering consumer direction; continuity of care provisions so individuals can maintain relationships with current providers; an advocate or ombudsman to help individuals understand their rights, responsibilities, and how to handle disputes with the managed care system or state; a critical incident management system)?
4. What considerations should be kept in mind when developing person-centered needs assessments, service planning, and care coordination requirements to meet the individual's medical and non-medical needs?
5. What would you consider to be the most significant features in assisting individuals to transition between providers and service/treatment settings?
6. What would make an MLTSS program attractive to individuals?

Provider Experience:

7. What program features do you see as important to providers who are making the transition to an MLTSS program (e.g., a payment floor, ease of authorization, billing, and payment processes)?
8. What would make an MLTSS program attractive to providers?

Service Package:

9. What are your recommendations for the design of a comprehensive and integrated supports and service package? For example, would you recommend community-based behavioral health services be included in the benefit package or be managed by a behavioral health services administrator?
10. What thoughts do you have on how DMAS should handle Fiscal/Employer Agent (F/EA) services for Waiver individuals who choose consumer direction of eligible waiver services? Should DMAS require that the health plans contract with the Department's designated F/EA or should DMAS give the health plans flexibility in determining how they want to provide or which entity they want to subcontract with to provide the F/EA services?

Health Plans:

11. What are your recommendations for health plan requirements (e.g., accreditation, offer a Medicare Advantage Plan with Prescription Drug Plan or a Medicare Special Needs Plan, experience providing services to special needs populations, other core competences)?
12. What strategies would you recommend the health plans utilize to maximize coordination with Medicare for individuals who are dually eligible?
13. What value-based payment opportunities would you suggest the health plans implement to reward providers for implementing health care transformation that could result in better clinical outcomes, improved member satisfaction, and cost containment under an MLTSS program?

Quality Measures:

14. Quality measures will help maintain accountability and transparency. In what areas of the program will it be most important for you to measure quality?

Financing:

15. Provide recommendations regarding financing, incentives, and other value based strategies to demonstrate high-quality, person-centered and cost-effective supports and services to individuals who are eligible for MLTSS.

Outreach and Communication:

16. What would be the most effective strategies for engaging individuals and providers in outreach and education efforts regarding a new MLTSS program?
17. What would be the most important messages individuals and providers would need to hear as they begin planning for transitioning to an MLTSS program?